CONTROL OF THE UTILIZATION OF INPATIENT HOSPITAL SERVICES

Utilization Review

The Department currently contracts with a Peer Review Organization (PRO) which performs review services to assess medical necessity, length of stay and quality of care provided to persons covered by medical assistance.

This review occurs in the form of prepayment review (prior to payment to the hospital) and postpayment review (following payment to the hospital).

Case demographic information is provided to the review organization from claims submitted to the Department for payment or claims for which hospitals have received payment. The review organization will provide at least 48 hours notice prior to the scheduled review for hospitals designated for on-site review. Hospitals designated for off-site review will be given seven days to submit copied charts by mail.

I. Medical Review Requirements

The Department, or its designee, may conduct preadmission, concurrent, prepayment, and/or postpayment reviews of:

A. The quality and/or the nature of the utilization of health services.

B. The medical necessity, reasonableness and appropriateness of inpatient hospital care for which additional payment is sought under the outlier provisions.

C. The validity of the hospital's diagnostic and procedural information.

D. The completeness, adequacy and quality of the services furnished in the hospital.

E. Other medical or other practices with respect to clients or billing for services furnished to clients.

Hospitals shall be notified at least thirty days in advance of any preadmission, concurrent, or prepayment review requirements imposed by the Department.

Hospitals and distinct part units that participate in Medicare (Title XVIII) must use the same utilization review standards and procedures and review committee for Medicaid as they use for Medicare. Hospitals and distinct part units that do not participate in Medicare (Title XVIII) must meet the utilization review plan requirements in 42 CFR, Ch. IV, Part 456, Subparts C, D, or E (October 1, 1991).

II. Utilization Review Conducted by the Hospital

The hospital Utilization Review Committee or designee must utilize the Department approved medical criteria when establishing medical necessity of a Medicaid hospital stay.

A. Initial Certification

1. A physician must certify for each patient the medical necessity for inpatient hospital admission.

2. The certification must be made within one working day after admission or within one working day after the hospital is notified of the application for Medical Assistance, or an individual who applies while in the hospital.

3. A physician, physician assistant or nurse practitioner, acting within the scope of the practice as defined by State law and under the supervision of a physician, must recertify for each applicant or patient that inpatient services in the hospital are needed.

B. Length of Stay Review

Each Title XIX (Medicaid) patient must have the length of stay, as initially certified reviewed by the Hospital's Utilization Review Committee. Such reviews can be conducted by the Committee or its designee.

III. Scope Of Work to be performed by State contracted PRO.

The Scope of Work to be performed by the PRO under this Agreement includes the following activities:

A. Provide the Department upon request with agreed upon reports of all review activity completed by the PRO.

B. Provide the Department with the following review and Hospital Monitoring Services:

1. Retrospective prepayment review of any outstanding emergency admissions prior to September 1, 1991 to hospitals which did not participate in the Department's Illinois Competitive Access and Reimbursement Equity (ICARE) Program. This review will include verification of the medical necessity of admission and continued stay as well as documentation of the emergency status of patients,
determination of stability date, potential quality issues and coding validation of all diagnosis and procedure codes.

2. Retrospective prepayment review of procedures from the Hospital Ambulatory Reform Inpatient Justification List for the purpose of determining medical necessity of admission and continued stay, determination of potential quality issues and coding validation of all diagnosis and procedure codes.

3. Retrospective prepayment review of all cases involving inpatient stays for Department of Children and Family Services (DCFS) wards and all specifically designated inpatient stays of 28 days or longer. This review will include verification of medical necessity of admission and continued stay, determining potential quality issues and coding validation of all diagnosis and procedure codes.

4. Retrospective postpayment review of a random sample of admissions selected by the Department for the purpose of verifying the medical necessity of the patient's admission and continued stay, determining potential quality issues and coding validation of all diagnosis and procedure codes. Analyses of postpayment review findings to identify trends, such as high referral rates for specific codes, types of care (i.e., obstetrics, pediatrics), or facilities which indicate the need to initiate prepayment review requirements or intensify postpayment review requirements. Postpayment review findings, verified at the physician reviewer level when appropriate, may also be used in the Department's recoupment process after reconsideration appeal, if any.

5. Retrospective postpayment review of a random sample of observation services selected by the Department to determine the appropriateness of the service for the treatment of the illness or injury, verify diagnosis and procedure codes and identify potential quality issues.

6. Retrospective postpayment review of day and cost outliers to determine the medical necessity of admission and length of stay, verify diagnosis and procedure codes, identify potential quality issues and, in the case of cost outliers, verify the hospital's charges.

7. Retrospective review for the presence and validation of the appropriateness of physician attestations. If no attestation is present, or if the attestation is blank or unsigned by the physician, an administrative denial will result. Attestation errors will be profiled to identify patterns of errors with results reported to the Department on a quarterly basis.

8. By mutual agreement, Contractor may perform special studies or review projects for the Department. These projects will be negotiated on an individual basis.

9. Postpayment review of DRG reimbursed readmissions within 30 days of initial admission.

10. Review of all inpatient transfers and referrals from one hospital to another.

11. Retrospective prepayment review of all inpatient psychiatric care provided to children, adolescents and adults which is billed with ICD-9-CM diagnosis ranges 290 through 302 and 306 through 319.

12. Retrospective prepayment review of specific ICD-9-CM diagnosis codes which have been identified through data analysis as having a high incidence of questionable care. This review will include verification of medical necessity of admission and continued stay, determination of potential quality issues and coding validation of all diagnosis and procedure codes.